



CHART NO: \_\_\_\_\_

DATE: \_\_\_\_\_

### PATIENT'S PERSONAL HISTORY

Patient Demographics Updated: \_\_\_\_\_ Confidential Record: Information will not be released without authorization.

Last Name	First Name	Middle Initial	Birth Date	Birth Place
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Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ Doctor: \_\_\_\_\_

Family or Referring Physician: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

Family History		If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters	Sex	Age	Health	Age at Death	Cause
	M F				
	M F				
	M F				
	M F				
Sons/Daughters	Sex	Age	Health	Age at Death	Cause
	M F				
	M F				
	M F				
	M F				

Immunizations Current:  Yes  No Dates of Last Tetanus: \_\_\_\_\_ Last Flu: \_\_\_\_\_ Last Pneumonia: \_\_\_\_\_

Do you know of any **BLOOD RELATIVE** who has had: (Circle and give relationship.)

Stroke: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_

Cancer: \_\_\_\_\_ Thyroid Problem or Goiter: \_\_\_\_\_

Heart Attack: \_\_\_\_\_ Bleeding Disorder: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_

Kidney Disease: \_\_\_\_\_

Personal Habits: (Circle yes or no.)

Yes No Do you use tobacco? What kind? \_\_\_\_\_ For how many years? \_\_\_\_\_

Yes No Do you drink alcohol? What kind? \_\_\_\_\_ How often? \_\_\_\_\_

Yes No Do you use any street drugs? What kind? \_\_\_\_\_ How often? \_\_\_\_\_

List all medications you take and the dose: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please complete the back page of this form.

Write in the names and year of any operations you have had:

Hysterectomy: \_\_\_\_\_ Other: \_\_\_\_\_

Heart Surgery: \_\_\_\_\_

Abdominal Surgery: \_\_\_\_\_

Cancer Surgery: \_\_\_\_\_

Circle or write in the names of chronic medical problems you have had and for how long:

Diabetes    High Blood Pressure    Kidney Disease    Lung Disease    Heart Disease    Cancer

Other: \_\_\_\_\_

\_\_\_\_\_

Women Only	Men Only
Are you having regular periods? _____	Have you had prostate problems? _____
Date of last period? _____	_____
How many pregnancies? _____	Have you had any hernias? _____
Date of last pap smear: _____	_____
Have you had an abnormal pap smear? _____	Date of last PSA test: _____
Date of last mammogram: _____	_____

**Review of Systems:** (Circle yes or no and explain.)

- Yes    No    Any fevers, sweats, or weight change? \_\_\_\_\_
- Yes    No    Any stomach or bowel complaints? \_\_\_\_\_
- Yes    No    Any headaches, dizzy spells, or weakness? \_\_\_\_\_
- Yes    No    Any problems with eyes? \_\_\_\_\_
- Yes    No    Any problems with ears, nose, or throat? \_\_\_\_\_
- Yes    No    Any chest pain? \_\_\_\_\_
- Yes    No    Any shortness of breath or cough? \_\_\_\_\_
- Yes    No    Any problem with bladder or kidneys? \_\_\_\_\_
- Yes    No    Any problem with back, joints, or feet? \_\_\_\_\_
- Yes    No    Any problem with nerves, depression, etc? \_\_\_\_\_
- Yes    No    Any increase in thirst? \_\_\_\_\_

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